State/Territory: New Hampshire

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ☐ No limitations ☒ With limitations*

2.a. Outpatient hospital services.

   Provided: ☐ No limitations ☒ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

   Provided: ☒ No limitations ☐ With limitations*

   ☐ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

   Provided: ☐ No limitations ☒ With limitations*

** Limitations in the State Plan may be exceeded with prior approval by the Office of Medical Services based on medical necessity.

*Description provided on attachment.

1. Inpatient Hospital Services

Payment for inpatient hospital services is limited to medically necessary days only. Medically necessary days are days of stay approved by the State agency responsible for utilization review or its designee, i.e. the Professional Standards Review Organization (PSRO) which evaluates the quality, necessity and appropriateness of care and renders length of stay determinations.

All accommodations and ancillary services are paid for each approved medically necessary day. The day(s) of discharge do not count toward the limit. No payment is made for days of stay beyond the determination of medical necessity.

Coverage of organ transplantation is limited as per Attachment 3.1-E.

2. Outpatient Hospital Services

a. Payment for outpatient hospital services is limited to twelve (12) visits per recipient per fiscal year.

c. Payment for federally qualified health center services is limited to federal requirements.

3. Other Laboratory and X-Ray Services

Payment is limited to fifteen (15) diagnostic x-ray procedures per recipient per fiscal year. This limit includes x-ray procedures when performed by a physician or an independent laboratory.

State/Territory: NEW HAMPSHIRE

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4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations X With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations X With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ___ No limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: ___ No limitations X With limitations*

OFFICIAL

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

OFFICIAL

*Description provided on attachment.

12a. Prescribed Drugs

A co-payment of fifty cents ($0.50) to the pharmacy by the recipient is required for each covered prescription and refill of a generic, branded generic, or single-source pharmaceutical product dispensed.

A co-payment of one dollar ($1.00) to the pharmacy by the recipient is required for each covered prescription and refill of a compounded product or a brand name preparation of a multi-source pharmaceutical product dispensed.

Co-payments are not required for the following:

1. family planning products
2. emergency services
3. individuals under age 18
4. services to pregnant women for such services that relate to pregnancy or to any other condition which may complicate the pregnancy
5. categorically or medically needy individuals who are institutionalized and required to spend all their income for medical expenses except for a personal needs allowance
6. services furnished to HMO enrollees by a health maintenance organization as defined in Section 1903(m) in which they are enrolled. Since prescription drugs are not dispensed by the one existing HMO provider, the co-payment exemption for HMO enrollees for prescription drugs is not applicable at this time. If HMO services are expanded to include prescription drugs, the co-payment exemption will apply.

Maintenance medication, which is defined as legend or non-legend medication to be used continuously for 34 days or more, is limited to a 34-day supply or 100 dosage units, whichever is greater.

12c. Prosthetic Devices

Prior authorization is required for the purchase of hearing aids and ear molds. A written request, supported by a physician's statement of medical necessity, must be submitted to the Medicaid Administration Bureau for hearing aids and ear molds.

12d. Eyeglasses

Payment for eyeglasses is limited to the following:

- one (1) pair of single vision glasses with lenses, provided that the refractive error is at least plus or minus .50 diopter according to the type of refractive error, in each eye.

- one (1) repair of glasses every 12 months, including replacement of the broken component(s) only.

- replacement of lenses or lenses and frames only when refractive error changes .50 diopter or more in both eyes.

- contact lenses, trifocal lenses, and occular prostheses under certain conditions and with prior authorization.

AMOUNT, DURATION AND SCOPE OF MEDICAL
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b. Screening services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Preventive services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Rehabilitative services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Skilled nursing facility services.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

c. Intermediate care facility services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

OFFICIAL

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED

13 a. b. c. d. Other Diagnostic, Screening, Preventive and Rehabilitative Services

These services are generally covered under other types of services described elsewhere in this plan.

Additional Diagnostic, Screening, Preventive and Rehabilitative Services reimbursed by Medicaid include:

- those provided for eligible adults and children within screening programs such as Head Start, the Public School systems, and medical and dental screening programs conducted as part of approved and organized day care programs.

- those provided under written agreement for eligible children by the various clinics conducted by the Title V agencies in the Division of Public Health.

Mental Health Services (Division of Behavioral Health) are covered as follows:

The limit for all community mental health services shall be $1,800 (Medicaid reimbursement) per recipient per state fiscal year. Medicaid recipients shall qualify to exceed the $1,800 limit if the community mental health program certifies that the recipient meets the criteria for one of the Division of Behavioral Health (DBH) eligibility categories.

Individual community mental health service limits shall also apply.

Any such services provided by an out-of-state provider require prior authorization for reimbursement.

Other Preventive and Rehabilitative Services covered include:

- those provided in a facility specifically designated for intensive inpatient rehabilitation services such as the Crotched Mountain Rehabilitation Center or one of such facilities in Massachusetts. Prior Authorization is required.

- adult medical day care services provided in a licensed facility. Payment for adult medical day care services is made only when the recipient is determined to be medically frail and/or elderly by a physician and is not residing in an institution. Recipients must attend adult medical day care for a minimum of two days per week, five hours per day. Prior authorization is required for this service.

- early intervention services include client centered family training and counseling, developmental training, speech therapy, occupational therapy, and physical therapy. Specifically excluded from coverage are direct child day care, case management, and child transportation; the latter two being Medicaid covered services already.

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Preventive services provided by a registered nurse (RN) to a newborn and his/her mother at their home to include a physical assessment, preventive health education, and assistance with connecting with a primary health care provider and the State EPSDT program.

Medicaid services provided in a licensed supported residential health care facility (private non-medical institution) must have prior authorization by the Office of Medical Services.

A private non-medical institution for children is a residential child care facility. Covered services must be prior authorized by the Division for Children, Youth and Families.

Therapeutic foster care must be prior authorized by the Division for Children, Youth and Families. Covered services are client centered family mental health counseling, individual counseling, crisis intervention and stabilization and medical care coordination. Services are not subject to the 12 visit per recipient per state fiscal year limit for psychotherapy services.

Intensive Day Therapy is covered when prior authorized by the Division of Human Services. Intensive Day Therapy is a package of services which can include case management, occupational therapy, physical therapy, speech therapy, and nursing services. Prior authorization is for a two (2) month period with a limit of six (6) months total. Recipient must generally receive a minimum of four (4) hours of service for five (5) days of each week.

Intensive Day Programming is covered when prior authorized by the Division for Children, Youth and Families. Based on a clinical assessment, each child receives an individually designed program of individual, group, and/or family system therapy and counseling. Services are not subject to the 12 visit per recipient per state fiscal year limit for psychotherapy services.

Crisis Intervention is covered when pre-approved by the Division for Children, Youth and Families. Covered services include therapeutic and intensive counseling, and are generally limited to a six week period. This service is available 24 hours per day, seven days per week. Services are not subject to the 12 visit per recipient per state fiscal year limit for psychotherapy services.

Child Health Support Services are covered when pre-approved by the Division for Children, Youth and Families. Covered services for foster children are provided by RN's and include a brief health screening at the time of the child's placement, referrals for comprehensive health and development assessments, health planning conferences, and follow-up care. Covered services for children in their own homes include an initial health assessment/health education, support counseling, and behavioral health management. Supervision of the services for children in their own homes is provided by a RN or licensed practical nurse (LPN). Supervision of the services for children in their own homes may be provided by a Master's level social worker, mental health worker or counselor when the services are support counseling and/or behavioral health management. Services provided to children in their own homes are usually limited to three (3) months.

Home Based Therapy Services are covered when pre-approved by the Division for Children, Youth and Families. Covered services include psychotherapy and mental health counseling and therapy. Services are not subject to the 12 visit per recipient per state fiscal year limit for psychotherapy services.

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Psychotherapy services provided by a clinical social worker, mental health counselor, marriage and family therapist, or other practitioner, who is certified by the NH Board of Examiners of Psychology and Mental Health Practice, and who is not on the staff of a community mental health center, are covered up to twelve (12) psychotherapy visits per recipient per state fiscal year--such visits to be counted toward the twelve (12) visit psychotherapy cap for all non-physician practitioners. The above providers must follow a treatment plan prescribed by a licensed practitioner who is licensed to provide psychotherapy services.

14a. Prior authorization is required before any payment is made for such services rendered out-of-state. No payment will be made for out-of-state care in an IMD if it is determined that the same care could have been provided in-state.

14c. Payment for intermediate care services in institutions for mental disease is available to categorically and medically needy recipients in need of such care. Payment for intermediate care services in institutions for mental disease must be prior authorized for a specified period of time based on the amount and length of care recommended by the recipient's physician. Determination of need for, and authorization of payment for, intermediate care services in institutions for mental disease is made by the Office of Long Term Care.